Medical/Service Provider Assessment

(Please complete this form legibly)

Patient/Client Name: _____ Date of Birth: _____

Name of Medical/Service Provider: _____

Circle Type of Provider: MD DO PA Psychiatrist Psychologist

Other (Please Specify): _____

Diagnosis: _____

_____

_____

Current Treatment and Medications: _____

_____

_____

Does this patient have a total permanent medical disability? YES NO

Is this patient able to work? YES NO

For what period of time will this patient be unable to work? LIFETIME TEMPORARY

If temporary, please provide a timeframe for when this patient can return to work: _____

_____

Other Notes: _____

_____

Please Print Name of Doctor: _____ Date: _____

Signature of Doctor: _____ License #: _____

Address: _____

Contact Number: _____

Clark County District Attorney Family Support Division Internal Use Only

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